



OPTIMAL SPINE
CHIROPRACTIC

2031 E GRAND AVE STE 301
LINDENHURST, IL 60046
(224)6437281

Date _____

First Name _____

Last Name _____

DOB _____

Sex Male Female

SSN _____

Address _____

City _____

State _____

Zip Code _____

Phone 1 _____

Home Mobile Work Other

Phone 2 _____

Home Mobile Work Other

Fax _____

Email _____

Employer _____

Employer Phone _____

Occupation _____

Job Status

Not Employed Employed

Part-Time Student Retired

Full-Time Student

Marital Status

Single Married Other

Receive Appointment Reminders

Declined Voice Text Email

Height _____ Weight _____

_____ ' _____ " _____ lbs

Reason For Visit: New Patient Adjustment Physical Consultation X-Rays Therapy Injury
 Report of Findings Auto Accident Re-Examination Other _____

Referred By: Provider Friend Family Other _____
Referred By Name _____

How Heard of Us: Walk in Referral Phone Book Website
 Advertisement Other _____

Demographics

Race: White Black or African American American Indian or Alaska Native Asian
 Native Hawaiian or Other Specific Islander Other _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown Other _____

Dominance: Right Left Ambidextrous



Emergency Contact Information

First Name _____ Relationship _____
 Last Name _____ Phone 1 _____ Phone 2 _____

Health History

Medications/Vitamins/Supplements:

Allergies:

Illnesses: Please check all that apply

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Other _____ | | | | |

Is there any history in your family for any of the above conditions?

Who? _____

What did they have? _____

Surgeries:

Traumas:

Complaints: (list your Chief Complaint first)

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.

Does the pain travel anywhere else? _____

Do you know what caused the problem? _____

Do you notice the pain during a certain time of day? _____

Frequency: _____ times per Day Week Month Year

Duration: Lasting _____ Minutes Hours

Onset: Have had symptoms over the past _____ Days Weeks Months Years

Intensity: Minimal Slight Moderate Severe

Is your condition: Same Better Worse

Rate your pain: 0 1 2 3 4 5 6 7 8 9 10
0 being no pain at all and 10 being the worst pain imaginable

Quality: Describe your pain: aching burning cramping deep dull numb radiating sharp
 shooting sore stabbing stiff swelling tight tingling throbbing

Aggravating Factors: What makes the problem worse? nothing most movements bending carrying things
 coughing driving eating exercise going down stairs going from lying to sitting
 going from lying to standing going from sitting to standing heat housework ice jogging lifting
 lying down massage pulling pushing running sitting sleeping sneezing squatting
 standing standing for a long period of time stress stretching taking a deep breath turning
 twisting walking working

Relieving Factors: What makes the problem better? nothing anti-inflammatories bracing chiropractic care
 elevation exercise heat ice massage movement pain killers rest stretching
 walking wraps

What daily activities are affected due to the problem? bathing caring for children cleaning climbing stairs
 cooking doing laundry dressing driving eating exercising going from laying down to sitting
 going from sitting to standing grooming house work laying down lifting oral care sex
 shopping sitting sleeping social/recreational activities standing stretching toileting
 transferring using technology using phone walking watching tv working yard work

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried for your condition? None Medication Surgery Physical Therapy
 Chiropractic Other _____

Are you presently under the care of a physical and/or mental health care provider? If so, by whom? _____

If so, what conditions? _____

Date of your last physical exam: _____ By whom? _____

Energy Level: Good Insufficient Erratic

Low (Time of Day) _____ High (Time of Day) _____

Sleep: Trouble falling asleep Trouble staying asleep Restful Other _____

Stress: None Low Moderate Severe What causes stress? _____

Have you had unexpected weight loss in the last 6 months? Yes No If yes, how much? _____

Daily Habits

Do you smoke? Never smoked Unknown if ever smoked Unknown if currently smokes

Current every day smoker Current some day smoker Former smoker

If yes, how many packs per day? _____ How many years? _____

Daily Caffeinated Beverages: Unknown None 1 to 3 4 to 6 7 to 10 11 to 15 16 to 20 21 to 25 Over 25

Weekly Alcoholic Drinks: Unknown None 1 to 3 4 to 6 7 to 10 11 to 15 16 to 20 21 to 25 Over 25

Do you exercise regularly? no light moderate heavy

Review of Systems

Musculoskeletal: Please check all that apply None

- Arm/hand pain back pain Feet/leg pain hip Knee Lower back pain Mid back pain Muscle or joint pain
 Neck pain Redness of joints Shoulder(s) pain Stiffness Swelling of joints Upper back pain

Cardiovascular/Respiratory: Please check all that apply None

- Chest pain, pressure or discomfort Cold hands/feet Coughing up blood (hemoptysis) Coughing up phlegm
 Difficulty breathing Dizziness/lightheaded Fainting Irregular heartbeat Palpitations Persistent Coughing
 Shortness of breath Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)
 Swelling (edema) Tightness in chest Wheezing Other _____

Head/Neck: Please check all that apply None

- Dizziness Facial pain Grinding Teeth Headache Head injury Hoarseness Jaw Clicks Lumps
 Migraines Pain Sore throat Stiffness Swollen Glands Tooth problems Trouble swallowing
 Other _____

Eyes: Please check all that apply None

- Blurred Vision Burning Cataracts Double vision Dryness Flashing lights Glasses/Contacts Glaucoma
 Itching Pain Redness Specks Vision Problems Other _____

Ears: Please check all that apply None

- Buzzing in ears Decreased hearing Drainage Earache Ear infections Poor balance Poor hearing
 Ringing in ears (tinnitus) Other _____

Nose: Please check all that apply None

- Allergies Blocked Sinuses Discharge Excessive mucus Hay fever Itching Nose bleeds
 Sinus pressure/pain Stuffiness/blockage Other _____

Throat/Mouth: Please check all that apply None

- Bleeding Blue lips Braces Dentures Difficulty swallowing Dry mouth Hoarseness
 Mouth pain Non healing sores Redness Sore throat Sores on lips or tongue Swelling
 Thrush Tooth pain Other _____

Urinary: Please check all that apply None

- Blood in urine (hematuria) Burning or pain Difficulty urinating Frequent urinary tract infections
 Frequent urination Incontinence Kidney infections Kidney stones Unable to hold urine (incontinence)
 Up at night to urinate Urgency Water retention Other _____

Gastrointestinal: Please check all that apply None

- Change in appetite Change in bowel habits Constipation Diarrhea Heartburn Nausea
 Rectal bleeding Swallowing difficulties Yellow eyes or skin (jaundice) Other _____

Endocrine: Please check all that apply None

- Change in appetite Cold intolerance Constipation Diarrhea Dry skin Excessive thirst
 Frequent urination Heat intolerance Sweating

Vascular/Hematologic: Please check all that apply None

- Calf pain with walking (claudication) Cold hands and feet Ease of bleeding Ease of bruising Leg cramping

Neurologic: Please check all that apply None

- Dizziness Easily angered/irritated Fainting Frequent crying Memory confusion Nervousness Neuralgia
 Numbness Poor concentration Seizures Suicidal thoughts Tingling Tremors Weakness
 Worry/anxiety Other _____

Psychiatric: Please check all that apply None

- Anxiety Depression Memory loss Nervousness Stress Other _____

Female:

Are you pregnant? Yes No

Number of pregnancies _____



Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

The above named clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named clinic.

Signature of Patient, Parent, Guardian or Personal Representative

Date _____

Print Name of Patient, Parent, Guardian or Personal Representative

Date _____